RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
	THREE Cs	
	COMMUNICATION	
1	Who can a consumer/family member call if they have complaints about CABHAs?	Individuals may call the Customer Service & Community Rights Team (919-715-3197), LME Performance Team (919-715-1294), or Accountability Team (919-881-2446) of DMHDDSAS. They may also call DMA (919-647-8000).

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
2	Today's topic is collaboration. Our agency has found that it very difficult to get responses regarding CABHA from DMH, in particular Steve Hairston's office. With the exception of Mr. Jordan's office (Extremely helpful). How can we get more cooperation and/or assistance?	In an effort to ensure that questions about CABHAs are consistently and efficiently, one DMH staff member is assigned to respond to CABHA questions. That person can be reached at: Contact.DMH.LME@dhhs.nc.gov
3	We need information about how to ask questions; need either one email address that actually gets answered or a list of how to direct questions based on topics. The IU defining how to direct questions is not working well. Particularly difficult to get answer on training issues.	
4	We need information on who you can contact at DMH and DMA that can answer specific questions. We do not need multiple email addresses for contact.	
5	CONTACTDMH email is completely ineffective. Communication with DHHS is a black hole, in that you rarely get an answer. Will you provide us with a more effective means to get our questions answered?	
6	Has DMA/DMH/DHHS given any thought to how communication can be more effective and more accurately distributed?	DMA and DMH/DD/SAS discuss the communication process and continue to give thought to improving the effectiveness and accuracy of communication. Implementation Updates will continue to be one method of communication. In addition, there is one DMH staff member assigned to respond to CABHA questions who may be reached at: Contact.DMH.LME@dhhs.nc.gov
7	Will DMH ensure better communication to providers when standards/requirements for UR change (e.g., VO states they have a directive from DMA and cannot do anything about it)?	
8	Can we expect Implementation Updates to resume and be one source of ongoing communication with CABHAs?	
9	Is there a process for DMH to notify LMEs when the Medical Director or Clinical Director positions are vacant? Is there a process for LME's to notify DMH if we learn about vacancies for QI Director, Medical Director, and/or Clinical Director?	DMH will notify LME CABHA Point of Contacts regarding vacancies of the 3 key positions. LMEs and CABHAs may email Mabel.McGlothlen@dhhs.nc.gov with information regarding vacancies for the 3 key positions.
10	What is the best way to notify DMH/DD/SAS of CABHA staff changes?	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
11	In regards to "Good Standing" - LME's were recently required to send DMA CABHA Transition Plans when 50% or more of the clients were discharged, moved to outpatient services or another non-CABHA service within the same company. Will DMA and DMH share that information with each other when reviewing the 106 new applications for CABHA?	Transition Plans of 50% or more of individuals discharged within the same agency are not included in the good standing definitions per the CABHA rules. Issues related to transition plans that may indicate an unsound practice will be responded to by State or LME review.
12	When will the Division publish clear and up to date guidelines and rules? (e.g. Incident Reporting – Updated guidelines and grids)	A new Incident Response and Reporting Manual is available on the DMHDDSAS website at http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm#incident
	COORDINATION and COLLABORATION	
13	Does DHHS talk with LME's about changing their culture of how they look at Mental Health Agencies and work with us?	DHHS meets with LME Area Directors regularly. We have had discussions regarding working with providers with the LME CABHA Point of Contacts over the past 6-9 months and will continue to discuss such issues in the future.
14	What are the opportunities/committees that providers can participate to be a part of the process and decision making?	Providers have been included in many committees and will continue to be invited to participate in committees. CABHAs interested in participating should contact their LMEs.
15	Are CCNCs being prepared to participate in a collaborative process with CABHAs? If so, how?	Yes. DMA and DMHDDSAS have been in ongoing collaboration with CCNC and the Office of Rural Health about CABHAs and how best to share information between CABHAs, primary care, the LMEs, and the CCNC networks.
16	What guidance can be offered to providers around sharing information with CCNC and creating procedures to ensure collaboration...will this be part of endorsement, FEM?	The CABHAs should be collaborating with their LMEs to work with CCNC. Confidentiality requirements of HIPAA and 42CFR Part 2 must be met in any sharing of information.
17	How do I collaborate with the LME Clinical Director when I can't identify an individual within the LME who is the Clinical Director?	Contact the Area Director of the LME to determine who the Area Director would like you to collaborate with regarding clinical aspects of services.
18	Will the LME-CCNC sharing of information be extended to direct connection between the CABHA and CCNC?	Some CABHAs have already been collaborating directly with their CCNC network and that is fine. Overall, however, it is hoped that LMEs and CCNC networks will share information, while CABHAs and direct primary care providers will share information more directly on the individual level. Confidentiality requirements of HIPAA and 42CFR Part 2 must be met in any sharing of information.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
19	Will there be a standardized protocol for collaboration with CCNC?	There is not a standard protocol at this time. However, there is ongoing discussion for the development of a plan for collaboration. CCNC & LMEs have already worked together to develop a protocol for sharing information with CABHAs. DHHS will be working with CCNC, LMEs, & CABHAs to strengthen and standardize that protocol.
20	Can the State provide a policy/protocol regarding how to navigate the CCNC network?	We would recommend speaking with your LME about navigating your local CCNC network.
21	What is the role of the LME, if CABHAs and primary care providers are collaborating and cross-referencing?	The LMEs role is to serve as liaison with the CCNC network, as needed, and to provide care coordination for individuals / families to ensure they are receiving the behavioral health services that they need.
22	How are we to be penalized for lack of collaboration with CCNC when they refuse to come to the table?	If a CCNC refused to come to the table, it would be important to document the efforts made to collaborate
23	How do we manage the roles of CCNC, PCPs, and our CABHA Medical Director? What if there are contradictory medical/clinical recommendations?	It would be important to have ongoing communication to maintain good working relationships and any contradictory recommendations would be taken care of on a case-by-case basis.
24	Who owns the patient/client when they go into the ED? (NOTE: Mobile Crisis refuses to assist ED and refer to the Provider who doesn't have the resources to work for EDs – including the hours of paperwork involved with ED.)	In regards to which agency has responsibility for an individual receiving services at a given time, if a Mobile Crisis provider is not accepting referrals from and ED, the LME should be asked to intervene and review the situation.
25	We are having difficulty obtaining "independent" evaluation for clients in Level III group homes. I have had occasions where I am treating the client and if I refer for evaluation, the receiving practice/CABHA will not perform an evaluation without assuming the care. As the treating physician, I strive to have that child move out of Level III as soon as it is clinically indicated. Greater clarification, especially following what is clinically indicated, would be much appreciated.	The LME should be contacted for assistance as it does not appear appropriate that the CABHA would refuse to perform an evaluation unless they are able to assume responsibility for the individual's treatment.
26	Since we are CABHA Providers now, why does different LME's have different requirements for getting MOA's?	All LMEs should honor the request for a MOA and there should not be different requirements by LMEs. IU #77 outlines the process for a currently endorsed provider to request an MOA to render that service to recipients residing in the LME's catchment area.
	FUTURE MEETINGS	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
27	Will the State develop an electronic forum for questions, suggestions, interpretation issues moderated by a State Authority? (eg. An open forum for providers)	The State has not designed such a forum at this point in time, but will take this suggestion into consideration.
28	Is it possible for there to be a quarterly CABHA Medical Director conference call with Dr. Nena to make sure all are on track/same page? (NOTE: It could be divided up by regions)	The Department will take this into consideration.
29	Can there be a theme of training on Recovery and Rehabilitation services for MH & SA service needs?	If this is a request for Recovery and Rehabilitation services to be a topic at future meetings, the Department will take this under consideration.
	CABHA LEADERSHIP	
	CLINICAL DIRECTORS	
30	How can clinical directors become involved in providing direct care services?	Clinical Directors are responsible for the oversight of the clinical aspect of the CABHA, Clinical Directors are to be involved as a supervisor regarding direct services, but may not provide direct services.
31	As clinical director how do you effectively supervise multiple sites?	Each provider agency may choose to do this differently; therefore, we encourage collaboration among Clinical Directors.
32	How do Clinical Directors provide good clinical leadership with multiple offices across state? What is the suggested form of supervision? (eg. SKYPE…If so, how do you document/get signatures? This is with an electronic database to monitor records). Can Clinical Supervisors provide supervision instead of the Clinical Director?	Each provider agency may choose to do this differently; therefore, we encourage collaboration among Clinical Directors. How this is done across the state will be based on the organizational structure of the individual CABHA. The Clinical Director supervises the clinical supervisors but is ultimately responsible for ensuring that supervision is provided according to individual need throughout the CABHA.
33	Although many things fall under direct-care, what are the “must-do’s” for clinical directors?	The responsibilities noted in the CABHA rules are the “must –dos” for the Clinical Director. See 10A NCAC 22P .0404.
34	Is any realistic consideration given to allowing clinical directors, to be able to provide a minimal amount of services in order to maintain clinical and diagnostic skills?	Not at this time
35	Can your full-time Clinical Director provide direct care after 5:00pm?	Not at the CABHA agency where the individual is the Clinical Director.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
	MEDICAL DIRECTOR	
36	The job description for the CABHA Medical Director is the same for a .5 FTE and a 1 FTE position. Due to time constraints, it is very difficult for a .5 FTE Medical Director to meet all of the requirements of the job description and also provide med. management services. Is there any consideration at the State to adjust this discrepancy in requirements?	There are no current plans to adjust the requirements of the Medical Director.
37	What are the expectations for a Medical Director whose CABHA site is not in your area to the other consumers served in the area? (eg. CABHA site is in ECBH area. Agency has sites and serves consumers in SER and Cumberland catchment areas.) Will Medical Director be expected to be involved with ALL LMEs and with the CCNC networks for ALL areas?	Yes, the Medical Director is expected to be involved with ALL LMEs and with the CCNC networks for ALL areas
38	If you are a 50% Medical Director who is already providing 12 hours of direct billable services, can you hire a PA to provide direct billable services under the Medicaid number of the Medical Director?	Yes, the PA can provide services incident-to the Medical Director. The SC modifier should be used and documentation should indicate who performed the service.
	CABHA REQUIREMENTS	
	CERTIFICATION	
39	Does a CABHA have to be re-certified if they add to their continuum? (eg. Adult CABHA wants to add services that would not meet requirements for child CABHA too)	The continuum for certification purposes includes only 2 services, one age and one disability. If a provider is certified and wants to add additional services, whether they be child or adult, that is acceptable, as long as the original two services approved for the continuum do not change.
40	We are a CABHA based on our adult continuum of services. However, the vast majority of our clients are children. We have a continuum in our child services, but are thinking about dropping one of those services. Is there any risk to our CABHA status if we stop providing one of our child enhanced services?	No, as long as the agency maintains the 2 services approved for the continuum and the related core services.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
41	What are the "Areas of Weakness" in CABHA applicants that Sandee Resnick mentioned? How do those areas get addressed specifically?	The main areas of weakness found during CABHA verifications were related to full integration of the leadership within the CABHA agency, full implementation of the Medical Director responsibilities and also full implementation of the Quality Management plans. As was discussed, much could be accounted for by the newness of the required activities, which is why these areas will be included in monitoring.
	ENDORSEMENT	
42	Are there any restrictions on LME Directors fulfilling the role of a licensed staff member on the clinical interview?	The LME Director should not participate in the Clinical Interview since the LME Director is involved in the appeal process at the local level.
43	The new endorsement policy requires a service provided within 60 days, but the endorsement letter requires you be enrolled prior to providing services. It took [our agency] 90 days to enroll our recently endorsed SAIOP/COT services...what is being done to address that discrepancy?	The policy requires the endorsing agency to monitor the endorsed site within 60 calendar days from the date of the DMA enrollment letter. The monitoring includes a review of compliance with the service definitions and sources of evidence indicated on the standardized check sheet items.
44	Have the state given any thought to pulling back on the Endorsement Policy effective January 1, 2011 as it conflicts with previous information communicated and either clinical policies?	The endorsement policy will be revised. A work group is currently reviewing the endorsement process as it relates to CABHA certified agencies. Statewide endorsement is under consideration. The Secretary is also appointing a committee to review duplication across a variety of monitoring processes.
45	Duplication of effort for LMEs and providers concerning Endorsement? If an agency is endorsed for a service...does it make sense that if any other region (within the provider) wants to become endorsed for the same service that they have to go through the process again? This also occurs within same regions that are having to be endorsed multiple times for the same service. (eg. Day Treatment required facility licensure and endorsement review for every site.) I support the 60 day review checkup, but to show the LME the same paperwork over and over is time consuming and a duplication of effort.	
46	When will we get relief from the multiple reviews? Why must we go through LMEs for endorsement? Why are we not endorsed 1 time for statewide delivery?	
47	Will there be statewide endorsement for CABHA services? (IIH, CST, Day Tx, Peer Support, and TCM)	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
48	Why does new endorsement policy apply to CABHAs? The process is very similar to the Interview and Desk process to become a CABHA. It is almost redundant to do the same process again when the agency is already endorsed with other LME and has been already certified as a CABHA.	
49	Why are there not 2 different endorsement policies for CABHA and non-CABHA agencies? (eg. We made it through CABHA; do you really have to make us do it again on an endorsement level?)	
	RULES	
50	I thought Performance Bond in the CABHA rules had been "suspended" until further review. Currently, it is in rule that the Performance Bond is required within 12 months of certification. If I'm a "early" certified CABHA, I have had CABHA related expenses much longer than newly certified CABHAs. This seems to once again be punitive to the early certified CABHAs who have incurred the expenses for a much longer time period. Any considerations to change to a date that would be fair to all CABHA certified agencies?	The Performance Bond requirement has already been extended once to the 12 month time period. The 12 month requirement in the rule is not expected to change. CMS approved the 12 month extension. Please note that CABHAs certified after the effective date of the rules (12/28/10) have 12 months from certification to obtain the performance bond. CABHAs certified prior to the adoption of the rules have 12 months from the date of the rules (12/28/10) to obtain their bond, per 22 P .0401 (f) "Within 12 months of certification or, if already certified, within 12 months of the adoption of this Subchapter, all certified CABHAs must obtain and submit evidence to the Division of Medical Assistance of a performance bond..."
51	What date was the CABHA rules approved?	Temporary rules were approved 12/16/10 and became effective 12/28/10. The rules are available at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services
52	10 ANCAC 22P.0302: Access to Care (f) What is considered "community-based services"...Basic Benefit and/or TCM?	Community Based Services are services offered in the community vs. institutional services. They include both basic benefits and TCM.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
53	Jim noted that section.0500 of the CABHA rules requires a CABHA that "changes their continuum" will need to submit the entire attestation again. Please clarify which section of the rule. I do not see this in rule.	Changes in the continuum are not addressed as such in the rules. However, the Department is implementing this to adhere to the certification requirements of the rule. There are multiple areas of the attestation packet that need to be reviewed to insure that the requirements are met for continuum changes (i.e. NEAs to insure endorsement, 35 mile requirement, 3 Key staff qualifications and experience with the population served/job descriptions/implementation of job duties, etc.)
54	"Change of Continuum" needs to be defined. Is this change from adult to child continuum - OR - if a provider drops CST and brings up ACTT?	Change of continuum means a change from a child continuum to an adult continuum or change from an adult to a child continuum. It also means change from a mental health continuum to a Substance Abuse continuum or change from a Substance Abuse Continuum to a mental health continuum.
55	10A NCAC 22P.0302 e (based on Kelly's slide) is a contradiction with the service definition for TCM and Basic. Do we go by the Service Definition or the CABHA rule?	You must follow the CABHA rule as it applies to the organization. It states that the CABHA must provide first responder services regardless of the requirements in the individual service definition.
56	Some rule language is unclear on page 5. "Retention" for example III (b) says to define it relevant to your services. Please clarify.	We were unable to identify this reference based on the wording of the question.
	WAIVER ENVIRONMENT	
57	Can the LME refuse to allow a CABHA to operate in their county, even if they qualify for endorsement? (eg. Piedmont...Can they still limit the number of providers to their liking?)	A LME with a 1915 BC Waiver, like Piedmont, can choose which agencies operate in their counties. All other LMEs must recognize that CABHA certification is a statewide status.
58	Why spend all this time/resource on gatekeeper functions (endorsement, licensure, certification, accreditation) if the intent is to move to 1915 b/c Waivers?	Licensure, credentialing, accreditation, and provider contracting for site and services are all activities which happen under a 1915 b/c waiver. (which make up the components as we currently know as endorsement).
59	How quickly can the State force mergers and waivers to control the growth of CABHAs?	There is no current plan to force any type of business arrangements on LMEs or providers.
	FINANCIAL ISSUES	
	BILLING	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
60	Please clarify the rule re. Medical Director (working 20%) not being able to bill for CABHA. Does this mean that the Medical Director cannot bill for Medication Management/evaluation for the CABHA?	20% Medical Directors may not provide any direct service within their 8 hours as MD. They may however, have an additional contract to provide direct services over and above the 8 hours they serve as Medical Director.
61	Is there any discussion regarding Medicaid paying for primary prevention services (eg. Psycho-education for mental health disorders)?	There is preliminary discussion on primary prevention at this time as a part of Healthcare Reform, but no policy has been developed.
62	Most TCM persons require more than 15 minutes per week...are providers going to be targeted for billing 15 minutes every week?	As long as the documentation for frequent billing of MH/SA TCM is clear and justifies the amount of service, a provider would have no reason to be "targeted". Should reviews take place because of large volume billing, if the documentation justifies the service, there would be no negative outcome.
63	(TCM) Can you bill 1 hour per week? I thought that it was 15 minutes per week.	There is a flat weekly rate for MH/SA TCM for any amount of service of 15 minutes or more. For example, you get paid the same amount for 15 minutes as for 6 hours. TCM must be delivered based on the needs of the person as documented in their person-centered plan/service plan.
64	If you have two Clinical Directors, can both of them bill for some therapy or another program for 20 hours or less?	Yes.
65	(SAIOP) - We have our consumers coming to group Mon, Wed. and Fri. for 3 hours in the evening. When a consumer is unable to come and we realize they came for 2 days, but miss the 3rd day, we cannot bill the whole week for the consumer. I was told by the LME that we can bill the 2 days. Is that true based on the service definition for SAIOP?	Yes, as long as the program operates three days a week and a person was there at least three hours per day on the days that were billed, and an audit would show that the person was scheduled to attend three days or week but missed a day.
66	If an agency also employs Physician Assistants or Nurse Practitioners, this would skew our 60% / 40% billing numbers as they bill on our MDs Medicaid #. How will this be monitored if you just look at his billing, in that it would look like he is billing a lot more than allowed?	The PAs and FNPs must use the "SC" modifier to indicate incident-to billing.
67	Billing for the continuum of services using our CABHA NPI number - We listed all the Medicaid numbers for our doctors and licensed professionals on our CABHA application, yet there are not instructions on how to do so for Med. Mgmt. and Outpatient Services. Can those be posted on-line?	Information on billing is posted online. Please refer to the Basic Medicaid billing guide found at: http://www.ncdhhs.gov/dma/basicmed/BasicMedicaid1010.pdf

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
68	Can a Clinical Director (100%) bill at all, even in the case of urgent/emergent need?	No, the Clinical Director may not bill for clinical services. The CABHA should be utilizing its licensed outpatient clinicians.
69	Can the State implement a way for licensed professionals to bill while they wait for their Medicaid number? (eg. Allow them to bill incident-to or under supervision contract).	While waiting for their Medicaid number, fully licensed professionals can practice at risk like enhanced providers. Once they receive their Medicaid Provider Number (MPN), they can submit an ORF with their enrollment letter requesting authorization that may go back to the date of their enrollment. They run the risk that the UR vendor may not approve the authorization because of lack of medical necessity. Once they receive the authorization, they may begin billing for services rendered.
70	Can a Clinical Director provide direct care services after they have met their 40 hour requirement? (eg. Evening OPT or CCAs)	Yes, however, CABHA rules states that a full time Clinical Director may not provide direct billable services to individuals who receive services from the CABHA.
71	When a person changes services they require a new Comprehensive Clinical Assessment. The CCA is only paid for once per year. How can you get therapist to get no reimbursement for a CCA?	There is no requirement for a new CCA when a person adds or changes a service. If the current CCA is not addressing needs to show medical necessity, the new service should not have been ordered or authorized, or additional assessments are needed. A Diagnostic Assessment can be billed only once per year, with the ability to request an additional assessment, if justified. There is nothing that limits CCA activity separate from a DA.
	PERFORMANCE BOND	
72	The performance bond has been added into the rules. The worksheet the bond company needs has not been released or I have not found it. Is there a timeline for providing this so it can be taken to the insurance company?	The CABHA can use the insurance company's bond form until the State's form is completed.
73	Where is the letter that agencies need to provide insurance company to receive performance bond?	
	OVERSIGHT	
	MONITORING and AUDITS	
74	Who will be monitoring the CABHAs? What agency?	DMHDDSAS and DMA will do in-house data reviews, DMHDDSAS, DMA and LMEs will partner in doing the onsite reviews.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
75	It appears that there are many more CABHAs than thought and the number of CABHAs are continuing to grow. The more CABHAs, the more resources are needed for monitoring, etc. Are there any thoughts on placing a moratorium like were done with Community Support on the CABHA process?	No.
76	What will be the schedule for CABHA reviews? Will this schedule be based on or related to the FEM in any way? Will someone be checking with the organization to ensure that they are not coming at the same time as accreditation, audits, etc.?	A schedule has not yet been determined. The FEM will be a piece of the information considered in determining a CABHA monitoring schedule. CABHAs that may be at risk for success, as well as CABHAs that don't show indicators for risk will all be monitored. We will make every effort to ensure that CABHA monitoring does not occur at the same time as other monitoring. That issue will also be addressed by the Secretary's workgroup on reducing duplication across DHHS agencies.
77	The 2nd to last slide in the presentation by Sandee Resnick is an excellent example of duplication, as all are being covered in LME & DHSR monitoring. Please consider eliminating the redundancy before implementation.	The area of Regulatory Compliance for CABHA Monitoring is meant to determine that the pre-requisites listed are still in place, and will be accomplished by reviewing data accumulated by DMHDDSAS and DMA with little impact on the onsite review. On-site verification will only occur when the information is not available in the central office.
78	What is the expected frequency of CABHA monitoring?	CABHA monitoring may be annual for a sample of certified CABHAs, may be triggered by complaints or by other concerns, and may be completed in conjunction with recertification at the 3-year mark.
79	Now that providers have electronic records, can we find a way to monitor and audit without printing the information?	We are addressing the need for audit and monitoring sites to be able to meet the electronic needs of agencies using advanced technology. There will likely be transition time where we may view records electronically, but still have to print copies of documents needed as evidence of deficiencies. CABHA monitoring will be on-site at the CABHA location, so any technology available there will be utilized.
80	Is there going to be only specific questions that will be asked on the monitoring tool? In other words, will there be an instance where questions will be asked that is not on the monitoring tool?	Only the questions on the tool will be asked, although there may be a variety of evidence presented to answer a question, which may spawn related questions to get to the needed information. The process will be similar to other monitoring events led by DMHDDSAS.
81	Will the State consider engaging CABHAs in the oversight process to encourage self-monitoring?	The Department will take this under consideration.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
82	For CABHAs with services in multiple LMEs, how will services be monitored which are located away from where the CABHA leadership is headquartered? (e.g., An organization with Day Treatment only in Wake Co., when leadership and the rest of the continuum is in Asheville)	CABHA Infrastructure requirements (leadership, quality management, etc.) relate to the entire agency and will be reviewed from that perspective. CABHA monitoring does not include individual service level monitoring as is currently completed by and will continue to be completed via local LME monitoring and Medicaid audits.
83	(Personal Interviews) How will these interviews be arranged with child consumers who are in DSS custody? Will interview be conducted with the child or the guardian or both?	Interviews with a child could not occur without the explicit permission of the parent or legally responsible person (LRP). The LRP will certainly be asked to include the child if appropriate. (An older teen could have great information to share, while a 6 year old may need a lot of support from a parent or LRP).
84	We understand that during monitoring you are looking for referrals from other CABHAs, but what about facility-based crisis or Emergency Departments (EDs)?	We will look at whether the CABHA considers the specific needs of the person and refers to the appropriate service, regardless of where it is offered. We will look at use of EDs compared to Facility-Based Crisis (FBC) and other community-based services to determine if the CABHA has gained capacity to respond to crises, beyond just the use of an ED or hospital. We will also look at whether the CABHA is accepting referrals from other agencies, including EDs and FBC, when appropriate. The DHHS will analyze claims data to determine patterns in use of EDs and FBC to decide when CABHA issues warrant a closer look.
85	For audits, specifically TCM, can providers be given a preparatory tool?	The Medicaid Audit Tool for MH/SA TCM audits to be conducted in March 2011 was posted on the web on Feb. 17, 2011.
86	(Collaborative Audit) – Can there be a “hold harmless”, for agencies that are going through the TCM audit because the State is “unsure” what they are looking for?	No. The state is not unsure what they are looking for. These are routine Medicaid documentation compliance audits which will determine compliance with the Medicaid MH/SA TCM service definition.
87	Who will make up the Division’s Advocacy and Customer Service staff and the Quality Management Team?	If this question relates to staff from those sections who will be involved in the monitoring process, that has not yet been determined. Otherwise, all members of these teams can be found on the DMHDDSAS website by clicking on the link “About the Division” and then "Division Contacts": http://www.ncdmh.net/staff/.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
88	Has there been a crosswalk listing of all requirements and regulation authorities (Medicaid, Rules, Accreditation, etc.)? (NOTE: This will be useful in analyzing the duplication/overlap and overhead costs in those entities conducting reviews and audits.	That task has been assigned within the Department and the results will be submitted for use by the new duplication workgroup.
89	Can we find ways to monitor the improvement of the therapeutic relationship and its security? (eg. We want to see the number of agencies people (consumers) have been through in a year's time to go down. Most of my new Med. Management patients have been through 2 or 3 in the past year)	The State will consider this when examining claims data for patterns and trends.
	POST-PAYMENT REVIEWS BY PCG	
90	Why would you want to use PCG in any additional capacity when they have messed up badly on audits?	Public Consulting Group (PCG) is the selected vendor to conduct post payment reviews for DMA-Program Integrity. Program Integrity conducts random sampling of cases reviewed by the Contractor to assess the accuracy of the Contractor's clinical decisions and inter-rater reliability. The sampling occurs throughout the life of the contract. PCG continues to perform the scope of work identified in the contract. The Division of Medical Assistance is also pursing an amendment to the contract for PCG to become the Recovery Audit Contractor (RAC) for North Carolina under Section 6411 of the Affordable Care Act and 1902(a) (42) of the Social Security Act. The RAC will audit Medicaid claims and identify underpayments or overpayments.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
91	Is it true that PCG gets a percentage of paybacks they find? What is their experience/education?	Public Consulting Group (PCG) receives a 7.75% of the amount of overpayment. PCG had to have at least 3-year history of successful performance of services similar to those delineated in the Scope of Work identified in RFP No. 30-DMA-256-10. PCG has extensive experience in the review of the delivery of behavioral health Services on behalf of Medicaid agencies. In 2008, PCG designed, developed, implemented and operated a process for performing clinical audits of provider-submitted claims for Community Support Services. PCG team has clinical review, claims and data analysis, technology, and project management experience. All clinical reviewers are licensed clinicians with mental health and/ or substance abuse experience with a minimum of two years experience in clinical review or delivery of behavioral health services.
92	Many CABHAs have already had audits by PCG. Some have had enormous paybacks. Accountability is a worthy and obviously necessary goal, but paybacks of 1/2 million dollars to $900,000 for well-intentioned agencies with very small reserves seem extremely out of proportion. There is great anxiety, often unspoken about this among CABHAs, especially because PCG is paid on a percentage basis. Is this really what the State wants, especially now when CABHAs are already under tremendous pressure financially and regulatory pressure?	PCG conducts post payment reviews on providers to determine if services were clinically and administratively appropriate according to generally accepted standards of care and NC Medicaid coverage policies, guidelines and procedures. PCG has not conducted audits of CABHAs at the State certification level. RAT-STATS software is the accepted standard for NC DMA Program Integrity and the United States Department of Health and Human Services, Office of the Inspector General. RAT STATS is used to determine a sample and the overpayment dollar amount based on the extrapolation method. The Division of Medical Assistance is also pursing an amendment to the contract for PCG to become the Recovery Audit Contractor (RAC) for North Carolina under Section 6411 of the Affordable Care Act and 1902(a) (42) of the Social Security Act. The RAC will audit Medicaid claims and identify underpayments or overpayments.
	QUALITY:	
	OUTCOMES	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
93	What kind of Quality Management [information] are you collecting from CABHAs and how will this be used?	DMHDDSAS and DMA will examine data from authorization requests, Medicaid and IPRS paid claims, outcomes documented in NC-TOPPS, complaints, incidents and other sources, as needed, to identify health and safety issues and service patterns, trends and outcomes. This information will be used to identify areas of concern and success and to develop action plans as needed to ensure that the CABHA initiative is successful across the whole state.
94	What tools are available for QM Directors to use from the Division?	DMHDDSAS publishes a variety of service utilization and outcomes reports on its website. Agencies can use these to set benchmarks to see how their services compare to local or statewide averages. DMHDDSAS also publishes audit tools and guidance that can help an agency identify issues that it should be monitoring internally. The Division is currently redesigning its website, which will include a Quality Management page.
95	How will consumers and families know if consumers are being well served by CABHAs?	The public can query the "Outcomes at a Glance 2.0" dashboard to see outcomes for enhanced services provided by CABHAs that participate in NC-TOPPS. A link to the dashboard is available on the DMHDDSAS homepage at http://www.ncdhhs.gov/mhddsas/. Individuals receiving services can request the "NC-TOPPS Individual Report" from their provider to compare their own progress to the dashboard averages. In addition, some providers conduct satisfaction surveys and consumers and families may ask to see the results of those surveys. Individuals with person-centered plans should be vigilant during the planning process to ensure they are being heard, and that the services and goals documented in the plan reflect their needs and what they consider to be important to them. Plans can be reviewed and revised at any time by request, and will be reviewed based on target dates for the goals. Attend the reviews and continue to voice concerns, needs and desires. Individuals / families may exercise their right to choice of providers if not satisfied with the services they are receiving.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
96	How quickly can we start using NC TOPPS? (specific to agency)	See the NC-TOPPS Quick Start Guide at http://www.ncdhhs.gov/mhddsas/nc-topps/systemuser/nctopps10-1-10quickstartguide.pdf . Provider-level outcomes are available on the public dashboard, Outcomes at a Glance 2.0, with a link available on the DMHDDSAS homepage at http://www.ncdhhs.gov/mhddsas/. This information can be used to set agency goals and benchmarks by comparing your agency's outcomes to other agencies serving similar age-disability groups.
97	Can we get NC TOPPS user-friendly data for real time use for agencies?	Providers can request their data files (data files available in SAS or Microsoft Access format.) Requests can be made through the NC-TOPPS Help Desk at: nctopps@ncsu.edu
98	Can NC TOPPS results start being reported by CABHAs?	All provider agencies registered in NC-TOPPS are shown in the public dashboard, Outcomes at a Glance 2.0, with a link available on the DMHDDSAS homepage at http://www.ncdhhs.gov/mhddsas/
99	Is NC TOPPS required for TCM?	Yes, for MH/SA TCM.
100	How do you set up NC TOPPS without site in catchment?	Each site location registers with all applicable LMEs served by that particular location. See NC-TOPPS User Enrollment at: https://nctopps.ncdmh.net/ci0708/assignlogins.asp
101	The Mecklenburg LME does not have a system to track admissions for NC TOPPS. The LME tracks the admission date by the actual referral date (when the client calls). It may take two or three weeks before the client comes into services due to not fault of the provider. This is inaccurate data. How can this situation by corrected?	The method for monitoring providers' use of NC-TOPPS is not standardized across LMEs. Contact Mecklenburg LME to address this issue.
102	I have heard that NC TOPPS will be required for consumers with Basic Services (ie. Only those receiving therapy and/or medication management). Is this true and can you provide logic as to why another requirement is placed upon providers?	There are no plans at this time to expand NC-TOPPS. However, some agencies have requested to use NC-TOPPS for individuals receiving core services and may do so on a voluntary basis.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
103	How can the State assist agencies in monitoring/measuring consumer outcomes besides NC TOPPS?	CABHA monitoring will include a standard set of interview questions which will be presented to people receiving services and to families, specifically designed to elicit information on progress toward personal outcomes. Also, the Council on Quality and Leadership (CQL) national accrediting agency uses an outcome-based focus in their monitoring protocols. The State publishes a number of reports about services and experiences of people receiving services, based on claims, surveys, and other data, on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm. CABHAs can compare their own performance to statewide patterns and trends to identify areas of success and areas for improvement.
104	Why does the State not mandate the use of standardized measures for outcome measurement similar to the mandates for Evidence Based Practices?	NC-TOPPS is the DHHS required outcomes measurement system for providers of enhanced services. It includes standardized measures that are used statewide and reported on the DMHDDSAS website by LME, provider agency, and age-disability group.
105	Now that programs are standardized with Evidence Based Practices, we need outcome measures that are aggregated by LME's…Will this occur?	
	SERVICES	
106	Why does the state not base state policy changes for services on Best Practices?	The Department makes every effort to base policy changes on best practice.
107	Will we ever see a situation where there is a nominal amount of unmanaged time for TCM so that our QPs can be an immediate support to consumers in need, but that our agencies can be reimbursed?	No, the requirement is that TCM must have an authorization in place prior to the provision of services.
	SERVICES	
	AUTHORIZATION	
108	How can we improve the clinical foundation of authorization process? (NOTE: Value Options renders questionable decisions on what is appropriate, clinical, and person-centered care.)	It is the goal of DMA to have authorization decisions made by Value Options be appropriate and clinically sound. Any suggestions as to ways to improve this process are welcome.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
109	Why is VO becoming "tighter" with Authorizations? It seems there is less flexibility within the authorization process. Denials and 'unable to process' have increased significantly.	Value Options is make authorization decisions based on medical necessity as outlined in Clinical Coverage Policy.
110	Is the State going to continue to contract with VO? Where are you with their contract?	An RFP for the statewide UR vendor for Mental Health Utilization Review was posted on 2/9/11 with an anticipated start date of a new contract in the Fall of 2011. The Vendor who will be providing the UR following the competitive procurement is dependent on the outcome of the selection process.
111	What can we do when we have a referral from or that originated from a non-CABHA who failed to properly discharge a consumer with VO, delaying a new authorization with CABHA agency?	This issue is addressed in Implementation Update #55, which states: "If the provider of record does not provide the UR vendor with the discharge ITR, the new provider contacts the LME (where the site/service of the provider of record is located). Keep in mind that the required authorizations for the exchange of information must be in place."
112	Send VO or the authorizing LMEs the provider numbers that weren't approved and have them discontinue the authorizations, so new providers can start new authorizations.	DMA has been coordinating with the UR vendors to ensure a smooth transition.
	CLINCAL HOME	
113	Who is the "Clinical Home" if the consumer has 2 CABHAs? (eg. Some referrals from TCM's want to provide wrap around services and continue to manage case even if referred for IIH with other CABHA. Additionally, it is better for consumer to keep TCM QP that they have been working with longer.)	The clinical home determination is based on the services that the individual is receiving at the CABHA. It is difficult to address this question as the example of TCM and IIH is not allowable at the same time.
114	Please clarify "Clinical Home" when client is in ED. (NOTE: Even with in-house resources, Providers are called to manage client when in ED. Decreased authorizations and long hours on provider staff are issues.)	If an individual is in the emergency department and the CABHA is called, they should respond if the individual is served by the CABHA. Their role is not to "manage" but to provide clinical consultative services as appropriate and medically necessary.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
115	Please provide clarification of "Clinical Home" versus "Medical Home" and the expenses related. (eg. Staff time, consumer outcome's cost, etc.)	CCNC is the Health Home for all NC Medicaid recipients. The Health Home should coordinate care with all specialty (including behavioral health) providers. While all recipients are assigned to a CCNC physician, not all recipients know their physician or are actively working with the physician for medical and other health care. The CABHA should make sure to link the recipient to their CCNC physician and coordinate care with the physician office. The CABHA is the behavioral health "clinical home" for recipients in the behavioral health system. "Clinical home" functions, such as development of the PCP, case management, and submitting request for authorizations are done by the "clinical home." "Clinical homes" within a CABHA are TCM, IIH, CST, SAIOP, SACOT, ACTT, MST, Child and Adolescent Day Treatment. They should provide case management (assessment, linkage, referral, monitoring) for all aspects of the individuals life—including physical health care. That physical health care should be coordinated with the CCNC Health Home.
	ENHANCED SERVICES	
116	What is the rationale for excluding/excusing pure SA and DD providers from the CABHA requirements/benefits?	CABHAs address the state's decision to "professionalize" treatment services for people with mental health and substance abuse concerns. We have worked long and hard to de-medicalize services for people with intellectual/developmental disabilities, so by intent that part of our umbrella service system provides habilitation under a different set of criteria. Waiver services for individuals with I/DD are progressing, with as an example, the new Self-Direction waiver just beginning.
117	Why are CABHAs not addressing any services or needs for the DD population? Why are MH&SA the only groups ever discussed/mentioned?...When all of the info. /handouts it is always listed as DMH/DD/SAS?	
118	How can you provide Community Support Team from a team approach of 3 people, with a 30 minute authorization? It's almost like the state is setting providers up for failure.	If an individual meets medical necessity for CST, units should be based on the needs of the individual within policy. If the units have been reduced to a 30 minute authorization, the level of care should be reevaluated.
119	The units for Community Support Team have been reduced tremendously. Can a consumer that has been authorized for few units be considered .5 consumer?	The team to individual ratio factored in the reality that some people will have higher need and others will have lower need.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
120	What if a provider does an assessment and the recommendation is CST? If we are the only agency in that catchment area providing CST and all our Teams have 45 individuals on their caseloads…How do you expect us to proceed with the new individual who has the clinically needs for this level of service and clearly meets all entrance criteria for CST (but does not meet ACT criteria) and it is felt PSR/OPT/ TCM would not adequately meet their needs. (Individual's anxiety prevents them from participation in group activities and has problems leaving their home)?	If capacity in CST is full: 1 - starting another CST might be considered 2 - referral to another team is also an option 3 - review of existing individuals on the current CSTs might allow for an individual to move to another level of care thus freeing up a spot on an existing CST 4 – Starting a new CST prior to reaching capacity is recommended.
121	Please clarify for SAIOP "48" hrs of service. Can you offer classes Tue, Wed, and Thurs. and be in compliance?	The SAIOP service definition states that there should be no more than two consecutive days between offered services, and therefore, services on Tuesday, Wednesday, and Thursday would be out of compliance with this policy.
122	Is there an environment of expectation that CABHA will be doing Peer Support?	It is strongly encouraged that CABHAs add Peer Support to their continuum. However, it is not a requirement. Peer support services are optional for CABHAs.
123	Will CABHAs be required to add Peer Support Specialist to their staff?	
124	Does the Peer Support Service account for the level of support required to support Peer Support Specialists in maintaining their recovery?	The weekly supervision requirements in PSS, by a licensed professional, help support the peer support specialist in their role.
125	Can CABHA Child MH perform TCM for adults?	Yes, if the staff providing the service have experience with the age and population being served per rule.
126	Can one provide an enhanced service in one CABHA, and another enhanced service in another CABHA? (eg. Direct care like IIHS, CST, etc.)	If the individual has the required knowledge, skills, and abilities with the population served and meets the staffing and FTE requirements for the service then they would be able to provide enhanced services in more than one agency.
127	("Client Flow") Can you please provide clarification when we want to refer a client to another CABHA for a specific service (eg. PSR)…Does the TCM/Case Management have to change to the receiving CABHA? (NOTE: We have encountered some situations where CABHA's will only serve the client if they provide all services. I foresee "specialized" CABHAs.)	Individuals have a choice in where they receive their services and can receive different services from more than one CABHA or provider at a time (e.g., CST, PSR, and Outpatient). This is a person-centered system.
	FIRST RESPONDER	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
128	Explain responsibilities of the "First Responder" versus the Mobile Crisis Agency.	The first responder should initiate the crisis response. Afterwards, if the crisis is outside the scope of the first responder's capabilities, a second level of response can be initiated such as Mobile Crisis. See the attachment to Communication Bulletin #35 (March 21, 2005) on the DMHDDSAS website at http://www.ncdhhs.gov/mhddsas/announce/commbulletins/all-commbulletin05.htm for details.
129	How can a provider be expected to provide "First Responder" to our consumers when authorizations for services are so limited? (eg. CST - 6 months of services...What happened to the consumer the other 6 months? Tell them that they cannot have a crisis?)	The CABHA is expected to provide first responder services to all individuals who are receiving any services from the CABHA.
	PERSON CENTEREDNESS	
130	Please address a process or mechanisms for addressing poor quality PCPs provided by non-CABHA or CABHA clinical homes. Currently we try to work with the provider to make improvements, but are ultimately left with not serving the client or moving forward with the poorly written PCP. Will the provider who is not the clinical home be held responsible for quality of the PCP?	The process would be for a provider to involve their LME and the LME could work with the provider to make improvements but, if improvements did not happened, the LME could consider removing the endorsement for a provider unable to provide quality services. As directly enrolled providers, agencies are responsible for information in the PCP related to their service provision. Ensure that the language in the goals and interventions related to the service you provide reflect what you know is important to the person and the treatment that is needed and desired by attending and participating in the person-centered planning meetings and reviews. Encourage the person to whom the plan belongs to speak up regarding the language and goals in their plan.
131	The PCP 1st Page Profile and PCP trainings provided by the Learning Community and other state-supported PCP trainings (ie. Lisa Bunting) are NOT providing the same direction/instruction to providers. Can this be corrected as audit for MH/SA TCM that are coming in early spring?	The Person Centered Thinking training available previously (non-explicit 6 hours) and the new explicit 12-hour curriculum are for teaching tools and skills to help people and providers think and listen in a way that supports what's important to and for the person receiving services. This training is not meant to teach how to complete the NC person-centered plan format. For staff who write plans, 3 hours of Person Centered Elements training is also required. The web-based version of this training is being revised to reflect the current PCP format.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
132	Re. Revision of PCP Signature Page: The box for the QP signature - There is a great deal of confusion about the DJJ section. We recently had a denial of authorization due to the "Meeting with Child and Family Team" box checked, but the 4th box in that section was not checked. Can you clarify?	We are working to revise the signature page of the PCP, as we recognize it is cumbersome at best. One of the first 3 boxes under the "Child Mental Health Services Only" part of Section II of the signature page has to be checked. In addition, the fourth box also must be checked. You may either have met with the C&F team, or scheduled a meeting, or assigned a TASC case manager, but you must also, in every case, have conferred with the LME for care coordination.
133	Can the doctor making a referral for enhanced services be the same doctor that signs the PCP? Can they be a psychiatrist working at the CABHA providing the enhanced service? (The Medicaid billing requires a referring doctor's NPI. Can this be the same person who signs service order on PCP?	Yes, the physician making the referral can be the same person who signed the PCP. Yes, they can be a psychiatrist working at the CABHA. Yes, this can be the same person who signs the service order on the PCP
134	Can we get support with the acceptance of Electronic and/or digital signatures on PCPs which have been created in Electronic Record Systems?	Yes. Any electronic signatures that follow a procedure that meets the requirements in the RMDM are acceptable.
135	Any consideration to reducing the PCP and paperwork requirements of MH/SA TCM? For a short-term service, the amount of paperwork does not make the service efficient or cost-effective.	Person-centered planning is one of the four components of TCM and therefore a major function of the targeted case manager in working with the individual / family to determine and address the needs of each individual. The PCP has recently been shortened in an effort to reduce the paperwork load.
136	Will the State consider eliminating the PCPs and replace with ITRs with basic short-term goals for treatment?	No.
137	Division needs to be more Person-Centered. Perhaps Division staff should attend 12 hours of PC Thinking.	Person-centeredness has been a core value of the Division since the beginning of Mental Health Reform. The Division has received a federal grant to support development of person-centered organizations, which includes training for State staff. We recognize that there is still much to learn and have convened a Quality Improvement Steering Committee that will support and expand the continued implementation of person-centered practices and principles within the state agency and across MH/DD/SA service system.
	STAFF ***CREDENTIALS***	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
138	(QM/Training Directors) - Can the credentials be waived or granted an exception? (Ex. No Bachelor's Degree, but individual be licensed such as a RN with an Associates Degree)	No, per rule 10A NCAC 22P. .0405 and .0406 QM/Training Director must have a Bachelors Degree or Masters Degree and 3 years or 1 year experience respectively. The temporary CABHA rules are available at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services
139	(QM/Training Directors) - In the Clinical Director requirements an individual can be licensed, but not necessarily have a Bachelors Degree, such as a NC Licensed Nurse Practitioner; however, the QM/Training Director must both have a minimum of a Bachelors Degree...Are there any situations where this would be waived and a licensed person would be allowed to fulfill either of these two positions?	
140	What is the logic behind DHHS emphasizing the use of non-masters level clinicians with, by definition, multi-stressed clients?	Non-licensed Masters level clinicians are supervised by a Master's level clinician.
141	Requirement of all staff on IIH to have one year experience, even the AP Can we relax the requirement on the AP so that they can get the experience?	No, this service is geared to addressing the needs of children and adolescents who are unable to remain stable in the community without intensive interventions, such as those afforded by this service, due to serious and chronic symptoms of an emotional, behavioral, and/or substance abuse disorder.
142	Are there any plans to upgrade the credentials for the CABHA Clinical Director position?	Not at this time.
143	Provisional Licensed staff need to be able to direct enroll with Medicaid.	Medicaid does not directly enroll provisionally licensed professionals.
	TRAINING	
144	Will DMH/DD/SAS re-look at standard training requirements for ALL staff in a particular service? (Direct treatment staff need an overview of PC Thinking and SOC, not the complete curriculum, PCT and SOC is great for QP/LP/Leadership staff in the service. Direct treatment staff need more crisis management/interventions, diagnosis, treatment intervention training.)	These trainings are a foundation for providing quality services therefore it is important that direct treatment staff receive the full training.
145	We are expected to provide significant training on a variety of service definitions and empirically validated treatments. Are there going to be guidelines/requirements for what constitutes qualified training?	The Clinical Coverage Policy and the Implementation Updates offer guidance as to what constitutes qualified training.
146	Will the State provide training grids for ALL services?	Yes, the training grid will be updated.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
147	In order to meet the service definition(s), will the Division definitely accept on-line Motivational Interviewing?	Online Motivational Interviewing training that is developed by a MINT trainer would be acceptable.
148	What required trainings for TCM, DAY Tx., IIH, have to be conducted by MINT Trainers?	A MINT trainer is required for the 13 hour motivational interviewing training for Community Support Team and Intensive In-Home.
149	When will the Motivational Interviewing be approved for agency trainers, if our Clinical Director has completed the trainer-the-trainer course?	Only MINT trainers will be approved to provide motivational interviewing training. MINT trainers are still required for training in motivational interviewing and this requirement will not change. Only a MINT trainer may provide the 13 hour introductory MI training required in CST and IIH.
150	Are MINT trainers still required for training Motivational Interviewing? Will the requirement change?	
151	Can an experienced and trained clinician provide Motivational Interviewing Technique training without being a MINT trainer?	
152	Is the ASO on-line training for Motivational Interviewing endorsed by the State...Does it count?	If the ASO online training is a 13-hour introduction to MI training developed by a MINT trainer, it would count.
153	PCT - Why is there a recommendation process with the Learning Community?	The Learning Community for Person Centered Practices' 12-hour curriculum on Person-Centered Thinking has been selected by the Department as the standardized curriculum to teach the philosophy that is needed to ensure that person-centered practices are driving our service system.
154	Why do we think that doubling the training requirements for person-centered thinking will make it more effective? Person-Centeredness, in terms of personal outcomes, should be devoted to outcomes versus focusing on training requirements.	The quality of person-centered plans over the past 5 years has been lacking with the undefined 6-hour course in person-centered thinking. This determined our need for a standardized person-centered thinking curriculum which includes teaching specific tools that can be used to help a person determine what is important to and for them, what is working or not working in their current treatment modalities, and where they hope to be in the future. Learning the use of these tools provides skills that can be utilized in any situation, on a person-specific, service-specific or agency-leadership level.
155	(PC Thinking – the 2nd 6 hours) Do I read correctly that the 2nd 6 hours can be done by our internal staff using the new State curriculum OR must we still used certified trainers?	The additional 6 hours of PCT training for staff who have the original 6 hours that were required can be done internally. The elements, as explained on the DMHDDSAS website, must be included within the curriculum by whoever provides the training.

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
156	If an employee has received 6 hours of PCT prior to the implementation of 12 hours effective 1/11, are they still required to receive the 12 hours prior to 3/31/11 or will this only apply to the new hires who have never received PCP at all?	Only the new hires will need the 12 hour course. Those with the previous 6 hours, if they have not changed agencies, will need to complete EITHER the 12-hour course or another 6 hours based on the elements listed on the DMHDDSAS website. If the person has had 6 hours previously and not moved agencies, the person may take a new 6-hour training based on State content elements or the Learning Community 12 hours. The new 6 hours may be taught by internal staff.
157	When can we expect the PCP Instructional Elements Training to be posted on the website?	We anticipate a revised PCP Instructional Elements training will be available online by the end of March 2011
158	Will there be a Standardized Recovery Orientation Training for CABHAs?	Standardized training in recovery orientation will be taken under consideration.
159	Who will actually teach the Wellness/Illness Management Recovery training that is required, if you choose this model? Does it have to be a Certified Agency? For instance, ECBH has developed their own curriculum that is BHRP approved. Would this count towards the 24 hours?	Who does the training is based on the requirements of the model. The wellness/illness management recovery training is one of the toolkits and the toolkit addresses the training requirements. As long as the curriculum meets those training requirements, it would count.
160	Can we get Clinical Leadership Training from the State?	The Department will take this under consideration.
161	Medical Directors need to have serious training regarding CABHA Medical Director's expectations. Will the State offer this?	The Department will take this under consideration.
162	Will the State offer training on Quality Management?	The Department will take this under consideration.
163	Will the State have a training on the monitoring tool and compliance for CABHAs?	Unlikely. The rules for CABHA certification are clear and easily accessible, and the monitoring will proceed as for any other reviews. Notice will be given; tools will be posted. If a CABHA continues to meet the requirements for certification and maintains its infrastructure, they should be in compliance during monitoring.
164	SOC & Family Partner - Why are they required to attend all trainings at the company's expense?	If staff are required to participate in training based on a service definition requirement, the costs of training are included in the rate of reimbursement for the service.
165	Can the training requirements be streamlined until providers (CABHAs) can afford it?	These trainings are a foundation for providing quality services therefore it is important that the staff are trained in a timely fashion. Training

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
166	Will there by any financial assistance with mandated trainings in the future, or perhaps new means to offset these costs?	costs are considered when setting rates. Given budget constraints, we encourage CABHAs to collaborate with each other, AHECs, LMEs , and community colleges to identify training that are affordable.
167	Consideration to extend training deadlines (timelines) - asking that dates for external training extended without penalty for a period until the State can show that trainings are available. (eg. SOC, MI, PCP). Currently, these trainings are not available in all regions. Can there be consideration for a 3-6 month extension...ie. Change 180 day rules to 1 year.	The current timelines remain in effect.
168	Will the State consider extending time frames for training requirements providing avenues where qualified professionals can do some of the training?	
169	Will the State consider an extension of the 30-day requirement to 90 days for TCM training?	The 30-day requirement for TCM is only for those individuals who have never provided case management services. Existing staff that have provided case management services have 180 days to complete the training.
170	What are the plans for accepting electronic training records? Currently, various monitoring bodies have different expectations regarding logs versus certificates and electronic signatures versus hard copies.	As long as electronic training records adhere to an agency's policy on how they receive and enter the data, and have safeguards so contents can't be changed, there would be no problem in reviewing training records in that way.
171	Are there any plans to implement further on-line training opportunities that CABHA agencies QM/Training Directors can implement/facilitate (eg. Person-Centered Thinking)?	There are no plans at this time to consider an on-line Person-Centered Thinking training. This training is completely interactive and best accomplished in small groups (25 – 30) face to face.
172	Implementation Updates clarify policy. If there are no IUs amending training requirements outlined in the July 10 Enhanced Service Definition (8a), are they correct until updated? Some of the LME Monitoring tools still have training requirements from IU from over 3 years ago.	Unless there is a an Implementation Update that amends the training requirements, what is in current Clinical Coverage Policy for enhanced services is currently in effect. The state will collaborate with LMEs to ensure that their monitoring tools are up-to-date.
	WORKFORCE	

RESPONSES TO QUESTIONS AT CABHA REGIONAL MEETINGS: Section 1

NUMBER	QUESTION	ANSWER
173	There is a concern for the lack of licensed professionals, provisionals, and team leads. How can we fill these open positions?	Both Divisions are working on workforce development issues. This is happening at the Division and Department level.
174	It is difficult to find CST team leaders in rural areas. Why not a QP team leader with Clinical oversight?	The purpose of the service definition revision was to increase the level of professional oversight in direct care.
175	How long does an agency have to replace a vacant position on the team? (eg. Psy., Nurse, CCAS, Peer Specialist, etc.)	If a team loses a position, the duties of that position should be filled by backup individuals immediately. It is expected that there will be backup staff to cover when an individual staff is unavailable. The CABHA should plan for these occurrences in advance.